Court, U.S.
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No.

In the Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,
Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Is ERISA § 502(a) an exclusive remedy provision that preempts state insurance law remedies that otherwise would be saved by the savings clause?

2. Do ERISA and FEHBA preempt state laws providing independent physician review of managed care organizations' medical necessity decisions?

LIST OF PARTIES TO THE PROCEEDING

The Petitioners are Jose Montemayor, Commissioner of the Texas Department of Insurance, and John Cornyn, Attorney General of the State of Texas. The Respondents are Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc. (now known as Aetna U.S. Healthcare, Inc.), Aetna Health Plans of North Texas, Inc. (now known as Aetna U.S. Healthcare of North Texas, Inc.), and Aetna Life Insurance Company.

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PETITION FOR WRIT OF CERTIORARI

The Fifth and Seventh Circuits conflict over whether *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), and ERISA §502(a) require preemption of state insurance laws that provide for independent review of medical necessity determinations made by managed care organizations. The conflict among the circuits over the preemptive force of §502(a) is not limited to these two circuits. The Fifth Circuit and other circuit courts read *Pilot Life* to hold that §502(a) is an exclusive remedy provision that preempts state insurance law remedies. The Second and Third Circuits hold that remedial state insurance laws can be enforced because they are expressly saved from preemption by ERISA §514(b)(2)(A), the "savings clause," and do not conflict with §502(a). The very purpose of Congress in enacting the savings clause is frustrated by the Fifth Circuit's holding that states cannot enforce the remedies provided in their insurance laws.

Not only is the states' right to enforce their insurance laws at issue in this case, the states' right to protect their citizens' health is at stake. The Texas independent review law reviews decisions that affect the health of citizens. Medical care likely will not be provided when a managed care organization determines that the care, despite being recommended by an attending physician, is not medically necessary. Texas exercised its traditional role to protect the health of its citizens by enacting an independent review law. No basis exists for the Fifth Circuit to conclude that Congress intended for ERISA §514(a) and FEHBA to preempt Texas' historical state right to regulate health care.

OPINIONS BELOW

The opinion of the court of appeals is *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526 (5th Cir. 2000). A published opinion denying panel rehearing and rehearing *en banc* is reported at 220 F.3d 641 (5th Cir. 2000). The opinion of the United States District Court for the Southern District of Texas is reported at 12 F. Supp.2d 597 (S.D. Tex. 1998).

JURISDICTIONAL STATEMENT

The court of appeals entered its judgment on June 20, 2000. The Texas defendants timely filed a petition for panel rehearing and petition for rehearing *en banc* on July 3, 2000. Both petitions were denied on July 27, 2000. This Court has jurisdiction under 28 U.S.C. § 1254(1).

FEDERAL STATUTES INVOLVED

The federal statutes involved in this case are the Employee Retirement Income Security Act of 1974 ("ERISA") and the Federal Employees Health Benefits Act ("FEHBA").

ERISA §502(a)(1)(B), 29 U.S.C. § 1132(a) (1)(B) provides:

> (a) Persons empowered to bring a civil action
> A civil action may be brought —
> (1) by a participant or beneficiary—
>
> . . .

> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

ERISA §514(a), 29 U.S.C. § 1144(a), provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section1003(b) of this title.

ERISA §514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

FEHBA, 5 U.S.C. § 8901(m)(1), provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supercede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

STATEMENT OF THE CASE

In 1997, Texas enacted Senate Bill 386 (SB 386),[1] amending the Texas Insurance Code to create an Independent Review Organization (IRO process).[2] The IRO process provides for independent, external physician-review of adverse determinations of medical necessity made by managed care organizations (MCOs).[3] An adverse determination is a decision that medical care an attending physician recommends be provided or continued is not medically necessary.[4] These medical necessity decisions directly affect the health of the

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[1] Act of May 22, 1997, 75th Leg., R.S., ch. 163, § 1, 1997 Tex. Gen. Laws 317.

[2] SB 386 also afforded Texans a number of other patient protections, including the right to sue managed care organizations that fail to meet an ordinary care standard for health care treatment decisions. The Fifth Circuit held these other protections were not preempted.

[3] MCOs include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and insurers and other entities involved in providing or arranging for managed health care.

[4] A decision that "health care services furnished or proposed to be furnished to a patient are not medically necessary" is defined as an "adverse determination" in the HMO Act and the Utilization Review Act (URA). TEX. INS. CODE arts. 20A.12A(a)(1), 21.58A, §2(3). The HMO Act provides that reviews of adverse determinations be made in accordance with the URA. *Id.* art. 20A.12A(c). Pursuant to the URA, adverse determinations for "health care services furnished" are subject to internal review by the MCO. *Id.* art. 21.58A, §11(a). Adverse determinations for health care services "proposed to be furnished" are subject to the IRO process and include concurrent and prospective requests for treatment, defined in the URA as "utilization review," but do not include requests for clarification of coverage. *Id.* art. 21.58A, §2(20).

insureds and enrollees of managed care plans because of the likelihood that denied care will not be obtained.

Aetna[5] sued the Texas Department of Insurance,[6] the Texas Commissioner of Insurance, and the Attorney General of Texas[7] alleging that ERISA and FEHBA preempted SB 386. [B-16.] The Fifth Circuit upheld the majority of the provisions, but held that the IRO provisions were preempted by ERISA §502(a)(1)(b) and FEHBA. The Fifth Circuit then severed the preempted provisions from the Act. [A-18.][8]

The Fifth Circuit rejected Texas' argument that medical necessity determinations are "mixed eligibility decisions" as defined by this Court in *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). [D-2-3.] Instead, it held that the IRO provisions "relate to" ERISA under ERISA §514(a). [A-11-12.] The Fifth Circuit applied *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999), to find the IRO process was a state insurance law, but nonetheless held that ERISA's insurance savings clause did not apply. [A-13-16.]

The Fifth Circuit interpreted this Court's decision in *Pilot Life* as requiring preemption of the IRO process because

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[5] Respondents collectively will be referred to as "Aetna."

[6] The district court dismissed the Texas Department of Insurance as a party pursuant to the Eleventh Amendment. [B-11.] Appendix citations appear in brackets to the page number in the Appendix; e.g., Appendix B at page 11 is [B-11.].

[7] Petitioners collectively will be referred to as "Texas" or "the State."

[8] The Texas Insurance Code provisions held preempted by the Fifth Circuit are reprinted in Appendix E.

the IRO provisions create a "quasi-administrative procedure" for review of benefit denials that conflicts with ERISA §502(a)(1)(b). [A-15.] Essentially, the Fifth Circuit held that ERISA §502(a)(1)(b) trumps the savings clause by preempting the field of state insurance law remedies. [A-15-16.] Additionally, the court of appeals held the IRO provisions were preempted by FEHBA. [A-17.] This petition for writ of certiorari seeks review of those conclusions.

REASONS FOR GRANTING THE PETITION

I. There is Conflict Among the Circuits as to the Preemptive Effect of ERISA §502(a).

The Fifth Circuit's interpretation of ERISA §502(a) directly conflicts with the Seventh Circuit's opinion in *Moran v. Rush Prudential HMO, Inc.*, 2000 WL 1551659, *12 (7th Cir. Oct. 19, 2000); *see id.* at *12 n.7 (Posner, J., dissenting from denial of *reh'g en banc*) (noting the "square conflict" between the Fifth and Seventh Circuits). In recent years, this Court has been called upon to resolve conflicting and incorrect circuit court interpretations of its ERISA preemption decisions. This case presents another such occasion.

In *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), the Court corrected the expansive and literalistic interpretation of ERISA's preemption provision, §514(a), that circuits erroneously thought *Shaw v. Delta Air Lines, Inc.*, 463 U.S.

85 (1983), required.[9] Next, in *Ward*, the Court clarified that in determining whether a state law was an insurance law saved from preemption under ERISA §514(b)(2)(A), not all of the McCarran-Ferguson Act criteria needed to be present. This resolved conflicting circuit court interpretations of *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), and *Pilot Life*. *See Ward*, 526 U.S. at 373. Now, Texas petitions the Court to resolve conflicting interpretations of ERISA §502(a)'s effect on the savings clause. In particular, at issue is the Fifth Circuit's erroneous interpretation that *Pilot Life* requires preemption of Texas' IRO process.

A. The Seventh Circuit's Decision in *Moran* Directly Conflicts with the Fifth Circuit's Decision in *Corporate Health*.

In *Moran*, the Seventh Circuit held that Illinois' independent review law was not preempted by ERISA. That decision directly conflicts with the Fifth Circuit's decision. The Illinois law, like Texas', requires independent physician review of a MCO's decision that the treatment recommended by an attending physician is not medically necessary. *See* 2000 WL 1551659 at *3.[10] The plaintiff, Ms. Moran, suffered from

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[9] *See De Buono v. NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806, 812-13 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325 (1997).

[10] The Texas and Illinois statutes are not mirror images, however. *Moran* concerned retrospective review for reimbursement for medical treatment provided. The Texas IRO process concerns prospective and concurrent requests that affect whether medical treatment will be

nerve compression syndrome and her doctors recommended microneurolysis surgery. *Id.* at *1-2. Her HMO, Rush, reviewed the request internally and determined the surgery was not medically necessary. *Id.* at *2. Nevertheless, Ms. Moran underwent the surgery and then sought reimbursement from Rush. *Id.* at *3. After being ordered by a state court to submit to an independent physician review, in which the surgery was found to be medically necessary, Rush again denied Ms. Moran's insurance claim. *Id.* at *4. She then asked the state court to enforce the independent review decision. *Id.* Rush removed the case to federal court claiming ERISA §502(a) completely preempted her reimbursement claim. *Id.*

The Seventh Circuit held that ERISA's savings clause applied to Illinois' independent physician review statute. *Id.* at *9. The Illinois statute, like Texas' statute, was held to regulate insurance under a common sense understanding and to meet at least two of the McCarran-Ferguson Act factors. *Id.* The Seventh Circuit held the statute was saved from ERISA §514(a) "relates to" preemption under this Court's decision in *Ward*. *Id.*

The Seventh Circuit, unlike the Fifth, held that a state independent review law is not preempted by §502(a). A claim to enforce the independent review decision "cannot be characterized as creating an alternative remedy scheme that conflicts with sec. 502(a)," because they are "not tantamount to the relief offered under sec. 502(a)(1)(B)." *Id.* at *11.

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provided or continued. *See supra* note 4; *see also infra* note 18.

Rather, independent review "simply adds to the contract, by operation of law, an additional dispute resolving mechanism." *Id.* The Seventh Circuit recharacterized Ms. Moran's claim as a benefits claim under ERISA §502(a) and distinguished *Pilot Life*. *Id.* at *12 (citing *Ward*, 526 U.S. at 375-76). By recharacterizing the claim, the court determined that *Pilot Life* did not require preemption. *Id.* Thus, the Seventh Circuit held the Illinois independent review law provided the rule of decision in Ms. Moran's ERISA §502(a) claim for reimbursement. *Id.* at *13.

The Seventh Circuit had previously ruled that state insurance laws can be enforced in a §502(a) proceeding. *Plumb v. Fluid Pump Serv.*, 124 F.3d 849, 862 (7th Cir. 1997) (holding an Illinois insurance statute becomes part of the substantive content of a plan, but does not conflict with ERISA's substantive scheme because an action to enforce the policy as modified by the state insurance law can only be brought under ERISA §502(a)). The Sixth and Eighth Circuits also hold that state insurance laws become part of the ERISA plan, but may only be enforced in a §502(a) suit. *See Ruble v. UNUM Life Ins. Co.*, 913 F.2d 295, 297 (6th Cir. 1990) (holding saved insurance laws modify the terms of the insurance policy, but "any action brought by a beneficiary to enforce the policy as so modified could only be brought under §502(a) of ERISA."); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) (holding that a saved state insurance law "will govern the interpretation of the [insurance] policy, but that does not effect the preemption of state law remedies

by §1132.").[11] The Fifth Circuit is thus in conflict with the Sixth, Seventh and Eighth Circuits.

Judges Posner, Coffey, Easterbrook, and Wood dissented from the denial of rehearing *en banc* in *Moran*. 2000 WL 1551659 at *12 n.7. They noted that the opinion "creates a square conflict with another circuit, is probably unsound, and will affect an enormous number of cases." *Id.* While Texas agrees that *Moran* presents a square conflict with *Corporate Health* and that both holdings will affect an enormous number of cases, the *Moran* analysis was not unsound.

In his dissent, Judge Posner reasoned that:

> If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the statute is and must be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy. It has regulated the contents of an ERISA plan–which means that it is preempted.

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[11] *But see In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1988) ("The Court in *Pilot Life* could not have stated with any greater clarity that the remedies under ERISA are exclusive, and no state law purporting to supply additional remedies will escape the preemptive effect of §1144(a) as laws 'which regulate insurance' under §1144(b)(2)(A).").

Id. at *12 n.7. This reasoning, however, misses the point of the savings clause entirely. States can regulate the contents of ERISA plans indirectly through direct regulation of the contents of insurance policies. *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) ("[I]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts.").[12] The Court reaffirmed this principle in *Ward*. 526 U.S. at 377. "We have repeatedly held that state laws mandating insurance contract terms are saved from preemption." *Ward*, 526 U.S. at 375.

B. *Moran* Is Consistent with this Court's Decision in *Ward*; *Corporate Health* Is Not.

Under this Court's decision in *Ward*, the Texas IRO process, as well as the Illinois independent review law, are saved from preemption in a §502(a) enforcement action. The IRO process creates a procedural right that an ERISA beneficiary can assert in a §502(a) enforcement action. This procedural right confers the state rule of decision to be used in a §502(a) proceeding. This is no different than the state insurance law this Court held was saved from preemption in *Ward*.

In *Ward*, the issue was whether a state rule of decision, the notice-prejudice rule, was applicable to an ERISA plan. *Id.*

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[12] The analysis also fails because an insurer or employer cannot usurp state regulatory authority by clever draftsmanship of a policy or plan. An insurer cannot "displace any state regulation simply by inserting a contrary term in plan documents." *Ward*, 526 U.S. at 376.

at 364. The ERISA plan provided disability coverage through an insurer and contained a notice provision that if not met barred benefits. *Id.* California law provides that such a notice provision cannot be invoked absent a showing of prejudice. *Id.* at 366-67. The Court held the rule was a law regulating insurance. *Id.* at 372.

UNUM contended that §502(a) preempted an action for benefits brought under the state law. *Id.* at 375. Because benefits were sought under §502(a) in that case, the Court did not need to decide if "§502(a) provides the sole launching ground for an ERISA enforcement action." *Id.* at 377. The Court ruled the notice-prejudice rule did not conflict with §502(a) even though the effect of the rule was to bind the plan to pay benefits, because "[t]he notice-prejudice rule supplied the relevant rule of decision for this §502 suit." *Id.*

Additionally, UNUM argued "that the notice prejudice rule conflicted with §503 of ERISA." *Id.* The Court rejected this argument because "[b]y allowing a larger period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulation." *Id.* If the notice-prejudice rule did not conflict with ERISA because it added to a procedural provision of ERISA, then Texas' IRO process, which complements ERISA's remedies, likewise is not in conflict.

The savings clause incorporates state law into the plan providing benefits, i.e., the mandated benefit law in *Metropolitan Life* and the notice-prejudice rule in *Ward.* "Here, the [IRO] provisions create a procedural right of the

insured against the entity." [A-14.] The IRO provisions are incorporated into ERISA plans and supply the relevant rule of decision in a §502(a) suit. Thus, to the extent the IRO process is relied upon in a §502(a) enforcement action, under *Ward*, it is not preempted by ERISA. The Seventh Circuit properly applied *Ward*, but the Fifth Circuit did not.

C. The Fifth and Other Circuits Misinterpret *Pilot Life*.

The Fifth Circuit interprets *Pilot Life* as holding that ERISA §502(a) precludes operation of the savings clause when state insurance law remedies are at issue. [A-15-16.] The Ninth and Eleventh Circuits concur. *See Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988); *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988). The Sixth, Seventh, and Eighth Circuits view *Pilot Life* as allowing for state insurance remedies so long as they are enforced in an ERISA §502(a) proceeding. *See supra* pp. 9-10. Texas submits that neither interpretation is correct, because *Pilot Life* did not involve a law regulating insurance within the meaning of the savings clause and is not controlling.

The plaintiff in *Pilot Life* sought extra-contractual damages for emotional distress and punitive and exemplary damages under Mississippi law for failure to timely pay a claim. 481 U.S. at 43. This Court reasoned that the claims based on Mississippi's law of bad faith "are firmly planted in the general principles of Mississippi tort and contract law" and that "[a]ny breach of contract and not merely breach of an

insurance contract, may lead to liability for punitive damages under Mississippi law." *Id.* at 50. Thus, the law could not be considered an insurance law subject to ERISA's savings clause.

Although this finding was sufficient for resolution of the matter, the Court went on to discuss whether §502(a) was an exclusive remedy provision. Based on an argument advanced by the Solicitor General,[13] the Court reasoned that Congress did not intend to provide remedies to ERISA beneficiaries in addition to those specified in §502(a). *Pilot Life*, 481 U.S. at 52. That analysis, however, does not resolve whether state insurance law remedies can be saved from preemption, because the law at issue in *Pilot Life* was not an insurance law.

This Court determined in *Ward* that it did not need to revisit *Pilot Life*, but nevertheless took the opportunity to clarify that *Pilot Life* was not a decision interpreting the savings clause. *Ward*, 526 U.S. at 376 n.7. Rather, *Pilot Life* "concerned Mississippi common law creating a cause of action

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[13] In *Pilot Life*, the Solicitor General argued that because §502(a) was patterned after §301 of the Labor-Management Relations Act of 1947, §502(a) should be considered an exclusive remedy provision. In *Ward*, the Solicitor General qualified its earlier argument, noting that the law at issue in *Pilot Life* was not a law regulating insurance. *Ward*, 526 U.S. at 376 n.7. The Solicitor General also explained that §301 did not have a savings clause, and thus could not be considered controlling in regards to saved state insurance laws. *See* Brief for the United States at *25, *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868), 1998 WL 839957.

for bad faith breach of contract, *law not specifically directed to the insurance industry and therefore not saved from preemption*." *Id.* (emphasis added). The Fifth Circuit's conclusion that *Pilot Life* is dispositive in this case is thus erroneous.

D. The Fifth Circuit's Decision Conflicts with Decisions of the Second and Third Circuits.

The Second and Third Circuits do not view *Pilot Life* as an obstacle either to saving state insurance law remedies from preemption or to enforcement of those remedies in a state proceeding. *See Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 151 (2nd Cir. 1995) (*Williams Trust*); *Pas v. Travelers Ins. Co.*, 7 F.3d 349, 356 (3rd Cir. 1993). The Second Circuit distinguished conflicting circuit court rulings by noting that those decisions "involve statutes that, while impacting upon the insurance industry, are based upon contract and tort principles." *Williams Trust*, 50 F.3d at 150. The Third Circuit simply said that to the extent other circuits reach "a result contrary to the one we reach here, our preference is understandably for our own result." *Pas*, 7 F.3d at 357.

The Second Circuit in *Williams Trust* gave effect to the plain meaning of the savings clause. 50 F.3d at 151. The savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). ERISA §502(a) is part of the subchapter referred to in the savings clause. Therefore, nothing in

§502(a) can be construed to prevent application of a state insurance law remedy.[14] The Second Circuit applied this plain meaning to save the state insurance law at issue in *Williams Trust*, holding "[i]t would be quixotic to rule that a claim under a state statute that is saved from preemption . . . may nonetheless be enforced only via ERISA provisions and remedies." *Id.*

The Fifth Circuit's and other courts' holdings that *Pilot Life* prevents insurance law remedies from being saved rewrite the savings clause. Now, state insurance laws that have the effect of ensuring that a promised benefit is provided cannot be saved. Insurance regulation serves one basic purpose—to make sure promised benefits are provided when needed. This is done through regulation of solvency and regulation of claims practices to insure that claims can and will be paid. *See Metropolitan Life*, 471 U.S. at 728 n.2. To say, as the Fifth Circuit has, that any state insurance law that has the effect of requiring the payment of a claim cannot be saved from preemption, is to defeat a fundamental purpose of state insurance law—law Congress expressly saved from preemption. *See id.* at 746-47.

The effect of an IRO decision—that a benefit is received because it is found to be medically necessary—is similar to the

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[14] The Solicitor General argued the plain meaning of the savings clause should be applied in *Ward*. "[T]he insurance savings clause on its face, saves state laws conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated benefits laws and other prescriptive measures that do so." Brief for United States, 1998 WL 839957 at *23.

effect of the law held saved from preemption in *Metropolitan Life*. There, the state law required the provision of mental health treatment. Here, the state law requires the provision or continuation of medical treatment if the IRO agrees with the attending physician. The result is the same under both laws. In one, a substantive right to mental health care is provided through inclusion of a mandated mental-health-care benefit in insurance policies. In the other, a procedural right to obtain medical care is provided through inclusion of a right to appeal an adverse determination in insurance contracts and certificates of coverage.[15]

The Third Circuit rejects the analysis that §502(a) precludes all state insurance law remedies. *Pas*, 7 F.3d at 356. *Pas* concerned whether an ERISA beneficiary could assert a claim in state court that termination of her insurance coverage violated New Jersey insurance law by discriminating against an insured with a disability. *Id.* at 351. Travelers sought mandamus when the district court remanded the state-law claim, arguing that ERISA preempted the state claim because "plaintiff's cause of action directly conflicts with the federal cause of action under ERISA §502(a)(1)(B)." *Id.* at 356. Aetna advanced precisely the same argument in this case, and the Fifth Circuit accepted it. The Third Circuit, in contrast, rejected the argument because it "misapprehends the requirements for conflict preemption." *Id.*

The Third Circuit applied conflict preemption analysis based on *Ingersoll-Rand Company v. McClendon*, 498 U.S.

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[15] TEX. INS. CODE art. 20A.09(e)(4).

133 (1990). There, this Court held that "if a statute is not expressly preempted by ERISA, it is nevertheless preempted if 'it conflicts directly with an ERISA cause of action.'" *Pas*, at 356 (citing *Ingersoll-Rand*, 498 U.S. at 142-45). The Third Circuit reasoned that ERISA did not provide a cause of action equivalent to the New Jersey insurance law and that it could not reasonably be contended "that any provision of ERISA expressly guarantees this same right." *Id.* Accordingly, the Third Circuit concluded "that a necessary requirement for conflict preemption is missing here." *Id.*

Likewise, ERISA provides no remedy comparable to Texas' IRO process. ERISA has no provision for review by an independent physician of an MCO's decision to deny medical care recommended by an attending physician. Thus, under the Third Circuit's ERISA conflict preemption analysis, the IRO provisions would be saved and enforceable in a state proceeding. This result is consistent with this Court's explanation of conflict preemption as applied to the savings clause.

ERISA "leaves room for complementary or dual federal and state regulation." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 100 (1993). Conflict preemption of state insurance law remedies occurs when the state law "cannot be harmonized or accommodated" with the federal law. *Id.* The fundamental purpose of ERISA is to protect ERISA beneficiaries and ensure that promised benefits are provided when needed. 29 U.S.C. § 1001. That is precisely what the IRO process and ERISA §502(a) are designed to do. ERISA, however, does not provide for an

independent review of medical necessity decisions. The IRO process thus complements the remedy provided in §502(a) and can be harmonized with ERISA. Accordingly, a necessary element for conflict preemption is missing here.

If the Fifth Circuit correctly held that any insurance law that binds a plan to pay a benefit is nevertheless preempted, then the savings clause would save nothing. This Court touched upon this erroneous interpretation of *Pilot Life* in *Ward*, but found that "whatever the merits of [this] view of §502(a)'s preemptive force, the issue [was] not implicated." *Ward*, 526 U.S. at 376. The merits of this view of §502(a) are squarely at issue in this case. Under the Second Circuit's plain meaning analysis and the Third Circuit's conflicts preemption analysis, state insurance law remedies are saved from ERISA preemption and can be enforced in state court proceedings. The Court should grant the petition for certiorari to resolve the conflict between the circuits and answer the two questions left unresolved after *Ward*. What is the preemptive force of §502(a)? Is §502(a) the sole launching ground for an ERISA enforcement action?

II. The Fifth Circuit's "Relates to" Analysis Conflicts with this Court's Decision in *Pegram*.

The Fifth Circuit's decision conflicts with this Court's analysis in *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). In *Pegram*, this Court discussed the mixed nature of medical necessity decisions. 120 S. Ct. at 2154. If a MCO or plan couches coverage in terms of medical necessity, then when medical treatment is determined to be medically necessary,

that implicates a MCO's or a plan's obligation to see that the treatment is provided. This Court held that medical necessity decisions do not involve an ERISA fiduciary duty, in part because they are medical in nature and states are free to regulate those decisions through their medical malpractice laws. *Id.* at 2155. This analysis is equally applicable to the IRO process. And the Fifth Circuit should have held that states are free to regulate medical necessity decisions through independent review laws.

A. The Texas IRO Process Is Health Care Regulation.

Independent reviews can address three general types of MCO decisions. First, independent review addresses treatment that is actually provided. In such a case, there is no doubt that treatment will be provided. There is no dispute that the patient's medical condition necessitates treatment and that various treatment options are covered under the plan. The only question is what treatment will be provided. These decisions can be termed pure treatment decisions and if the MCO and attending physician provide the wrong treatment, then they can be held liable for malpractice.

In connection with SB 386's liability provisions, an independent review for pure treatment decisions is provided. Use of the independent review is a prerequisite for filing a liability action, if the MCO chooses to comply with Texas'

utilization review requirements.[16] The Fifth Circuit held this independent review was not preempted because it was voluntary. [A-12.]

Second, at the other end of the spectrum are reviews of whether medically necessary treatment is covered or excluded from a plan. These are pure coverage decisions, or, as denominated in *Pegram*, "pure eligibility decisions." 120 S. Ct. at 2154. The IRO process does not address pure eligibility decisions, because requests for clarification of coverage are specifically excluded.[17]

Third, medical necessity decisions that trigger coverage are "mixed eligibility decisions." *Id.* These decisions arise because MCOs and plans define coverage in terms of "medically necessary care." They involve the exercise of medical judgment to determine the treatment a patient needs. These are the decisions that the IRO process reviews and that the Fifth Circuit held were preempted by ERISA and FEHBA.

The Fifth Circuit held without detailed analysis that the IRO process "relates to" ERISA plans. The IRO process was subject to preemption under §514(a) because the Fifth Circuit concluded the IRO process reviews coverage decisions and was thus "squarely within the ambit of ERISA's preemptive reach." [A-13.] This reasoning is reminiscent of the reflexive

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[16] TEX. CIV. PRAC. & REM. CODE §88.003. Failure to comply with Texas' utilization review statutes, including the IRO process, does not allow an MCO to rely on §88.003 in a liability action. *Id.*

[17] TEX. INS. CODE art. 21.58A, §2(20).

approach the circuits took to "relates to" analysis after this Court's decision in *Shaw*. Then, circuits took such a literal view of "relates to" analysis that virtually any state law would be preempted.

This Court reasoned in *Travelers* that the circuits' literal interpretation of *Shaw* was erroneous because if it were valid, then "for all practical purposes preemption would never run its course." *Travelers*, 514 U.S. at 655. Notably, the Court observed that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661. The IRO process is health care regulation because of the nature of the decisions reviewed. They are medical in nature.

Managed care places MCOs in "an active role in determining the course and scope of medical treatment." J. Scott Anderson, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431, 434 (1998). MCOs are "substituting their judgment for that of the attending physician providing care." *Id.* Whether MCOs make wrong medical necessity decisions because of cost containment concerns or just poor medical judgment, the consequences are the same. In concurrent and prospective utilization review health care is affected, because the likely result of an MCO overruling the attending physician's judgment as to medical necessity "is that the patient will forego the treatment." *Id.*

The IRO process is limited to the review of concurrent and prospective requests for treatment, and thus directly implicates the health care provided to Texans. *See supra* note 4.[18] In *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir.1992), the Fifth Circuit held the administrative aspect of a medical necessity decision was more important for ERISA analytical purposes than the medical aspect.[19] The Fifth Circuit acknowledged the medical aspect of the IRO process in *Corporate Health*, but steadfastly adhered to its previous analysis in *Corcoran*. [D-2-5]. This holding ignores the nature of the decisions reviewed by the IRO process, the consequences of erroneous decisions, and this Court's analysis in *Pegram*.

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[18] The *Moran* case did not involve concurrent or prospective review, in which the consequences of an erroneous decision affect the health of citizens directly and immediately. *Moran* was concerned with retrospective review to determine a reimbursement claim. The Seventh Circuit agreed "with the parties that [the independent review law] 'relates to' ERISA plans because its provisions have a connection with such plans." 2000 WL 1551659 at *8. Thus, there was no discussion of *Pegram*. Although retrospective review includes the exercise of medical judgment, the health care consequences of a patient foregoing treatment are not involved, as they are in concurrent and prospective review.

[19] *Corcoran*, 965 F.2d at 1331 ("Ultimately, we conclude that United makes medical decisions - indeed, United gives medical advice - but it does so in the context of making a benefit determination."). Commentators have criticized the Fifth Circuit's analysis because "[t]he fact that the outcome of a medical decision may entail consequences regarding whether a treatment would be paid for does not change the nature or manner of the decision." Peter D. Jacobson & Scott D. Fomfret, *Form, Function & Managed Care Torts: Achieving Fairness & Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 1037 (1998).

B. Texas' IRO Process Does Not "Relate to" ERISA and FEHBA Plans Under this Court's Analysis in *Pegram*.

In *Pegram*, this Court discussed the mixed nature of medical necessity decisions. 120 S. Ct. at 2154. *Pegram* concerned a claim under ERISA by a plan participant that an HMO breached its ERISA fiduciary duty because it financially rewarded doctors when they did not provide care. *Id.* at 2147. The Court reasoned that the alleged fiduciary decisions, medical necessity determinations,[20] were mixed eligibility and treatment decisions. The Court explained that:

> What we will call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?

Id. at 2154. These "eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* "The eligibility decision and the treatment decisions [are] inextricably mixed, as they are in countless medical administrative decisions every day." *Id.*

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[20] The Court relied on Herdrich's brief to clarify that the breach of fiduciary duty allegations "target[ed] *medical necessity determinations*." *Pegram*, 120 S. Ct. at 2155 (emphasis added).

The medical nature of the decision reviewed by the IRO process is indisputable. The Fifth Circuit went so far as to characterize the IRO process as "simply a second opinion on medical necessity about which reasonable doctors might reach differing conclusions." [D-5.] Despite the recognition that the IRO process reviews medical decisions, the Fifth Circuit found that this Court's analysis in *Pegram* was not contrary to *Corcoran*. [D-2-3.] Although *Pegram* concerned a decision by an attending physician, not a utilization review agent, the "mixed eligibility" analysis in *Pegram* is directly applicable to this case.

This Court recognized in *Pegram* that utilization review contains a medical component. 120 S. Ct. at 2149. It is this medical component that the State seeks to regulate. In discussing the development of managed care, the Court described the method of utilization review used by MCOs to control costs and thereby affect the care provided. The Court explained that HMOs

> commonly require utilization review (in which specific *treatment decisions* are reviewed by a decisionmaker other than the treating physician) and approval in advance (precertification) for many types of care, keyed to standards of *medical necessity* or the reasonableness of the proposed treatment.

Id. (emphasis added).

The IRO process reviews the medical judgment exercised in a "mixed eligibility decision." The purpose of the IRO process is to decide whether the MCO correctly determined the "appropriate medical response" to a given "patient's constellation of symptoms." *Id.* at 2154. The issue is what medical response a patient's condition necessitates. Even though treatment and coverage decisions become inextricably mixed because of the nature of managed care, that does not change the medical nature of the decision.

Although *Pegram* was not a preemption case,[21] the Court noted that Congress did not intend ERISA to preempt general state health care regulation. "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.* at 2158. The IRO addresses the central issue of health care regulation— is medical treatment necessary?

If Congress did not intend to impose ERISA fiduciary obligations on HMOs for medical necessity decisions,[22] then there is no reason to think, nor is there any legislative history to show, that Congress nevertheless intended that ERISA preempt state regulation of medical necessity decisions. Despite the immediate and apparent parallel between the Court's analysis of mixed eligibility decisions and utilization review, the Fifth Circuit did not find the Court's analysis in

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[21] *See Pegram*, 120 S. Ct. at 2154 n.9.

[22] *See Pegram*, 120 S. Ct. at 2155.

Pegram applicable. [D-2-3.] The Fifth Circuit's decision cannot be reconciled with this Court's analysis in *Pegram*.

The congressional purposes of fostering health care cost containment and preserving state health care regulation can be reconciled. The Court need only grant the petition for writ of certiorari and extend *Pegram* to hold that state independent review laws do not "relate to" ERISA and FEHBA plans[23] because there is no clear manifestation of congressional purpose to preempt state regulation of "mixed eligibility decisions." Then, while MCOs manage the costs of health care through utilization review, states can protect the health of their citizens through independent review.

III. Whether ERISA and FEHBA Preempt State Independent Review Laws is a Question of National Significance.

Many states now protect the health of their citizens through some form of independent, external review process.[24]

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[23] FEHBA preemption would be resolved because FEHBA preemption also entails a "relates to" analysis. 5 U.S.C. § 8901(m)(1).

[24] 2000 Alaska Sess. Laws 99; ARIZ. REV. STAT. ANN. § 20-2537 (West Supp. 1999); CAL. [INS.] CODE § 10169 (West Supp. 2000); COLO. REV. STAT. § 10-16-113.5 (West 1999); CONN. GEN. STAT. § 38a-478n (West Supp. 2000); DEL. CODE ANN. tit. 16, § 9119 (2000); D.C. CODE § 32-571.7 (Lexis Supp. 2000); 2000 Fla. Laws ch. 00-256 (West); GA. CODE ANN. § 33-20A-32 (2000); 2000 Haw. Sess. Laws 250; 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000); IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000); IOWA CODE ANN. § 514J (West 2000); KAN. STAT. ANN. § 40-22a13 (Supp. 1999); 2000 Kentucky Laws Reg. Sess. 262 (West); LA. REV. STAT. ANN. § 22:3081(2000); 2000 Me. Legis. Serv. 742

When an MCO makes an erroneous medical necessity decision, the likely result is that the patient will forego needed treatment. This can lead to tragic consequences. Neither ERISA nor FEHBA provide this critical patient protection. Whether ERISA and FEHBA preempt state laws creating independent reviews of MCO medical necessity decisions is thus a question of paramount importance worthy of Supreme Court review.

Independent review "serves as a safety valve" to correct mistakes or ill-advised decisions by MCOs.[25] "[C]oncerns about managed care incentives that might lead to the inappropriate denial of care" are likewise addressed by

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(West); MD. CODE ANN. [INS.] §§ 15-10A through 15-10B (Lexis Supp. 1999); 2000 Mich. Legis. Serv. 251 (West); MINN. STAT. ANN. § 62Q.73 (West Supp. 2000); MO. REV. STAT. § 376.1385 (1997); MONT. CODE ANN. § 33-37-102 (1999); N.H. REV. STAT. ANN. 420-J:5 (2000); N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000); N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000); N.Y. [INS.] LAW §§ 4904 (McKinney 1999); N.C. GEN. STAT. §§ 58-50-61, 58-50-62 (1998); OHIO REV. CODE ANN. § 1751.84 (Baldwin Supp. 2000); OKLA. STAT. ANN. tit. 63, § 2528.3 (West 1999); 40 PA. CONS. STAT. §§ 991.2161 *et seq.* (1998); R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000); 2000 S.C. Acts 380; TENN. CODE ANN. § 56-32-227 (West 1999); UTAH CODE ANN. § 31A-22-629 (2000); VT. STAT. ANN. tit. 8, § 4089f (1998); VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000); 2000 Wash. Legis. Serv. 5 (West); 2000 Wisc. Legis. Serv. 155 (West).

[25] Karen Pollitz, Geraldine Dallek, and Nicole Tapay, Institute for Health Care Research and Policy Georgetown University, *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare* (Nov. 1998), p.49 <http://www.kff.org/content/ archive/1443/review_r.pdf> (prepared for the Henry J. Kaiser Family Foundation.)

independent review.[26] Because of these salutary effects, in addition to Texas, thirty-seven states and the District of Columbia have established some form of external review.

The states have a right to establish checks and balances over managed care through independent review laws that protect the health and well-being of their citizens. Nothing in the language of ERISA or FEHBA or their legislative history supports the Fifth Circuit's conclusion that Congress gave MCOs carte blanche to substitute their medical judgment for that of an attending physician's free of state regulation. This misconception of the purpose and intent of Congress in enacting ERISA and FEHBA should be dispelled by this Court.

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[26] Geraldine Dallek and Karen Pollitz, Institute for Health Care Research and Policy Georgetown University, *External Review of Health Plan Decisions: An Update* (May 2000), p.1, <http://www.kff.org/content/archive/3020/review_r.pdf> (prepared for the Henry J. Kaiser Family Foundation.).

CONCLUSION

For these reasons, the petition for writ of certiorari should be granted.

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